Health Care Administrative Rules Definitions

1.101 Health Care Administrative Rules Definitions (12/16/2016, GCR 16-076)

For the purposes of these Health Care Administrative Rules, the term:

"Agency" means the Vermont Agency of Human Services or any of its departments, offices, or divisions.

"Beneficiary" means any individual eligible to have benefits paid to him or her, or on his or her behalf, under Vermont Medicaid.

"Centers for Medicare and Medicaid Services" or **"CMS"** mean a federal agency within the U.S. Department of Health and Human Services. Programs administered by CMS include Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the federal Health Insurance Marketplace.

"Code of Federal Regulations" or **"CFR"** mean the codification of rules published in the Federal Register by the departments and agencies of the Federal Government.

"Early and Periodic, Screening, Diagnostic, and Treatment" or **"EPSDT"** mean the items and services defined in 1905(r) of the Social Security Act which include screening, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Plan.

"Global Commitment to Health Waiver" means a Medicaid Demonstration Waiver authorized by Section 1115 of the Social Security Act, which provides Vermont Medicaid with federally approved waivers of specific requirements of the Social Security Act that would otherwise apply to Vermont Medicaid. These waivers provide Vermont with expenditure and policy authority to expand Medicaid eligibility and to pay for programs and services that promote the objectives of the Medicaid program outside of the Medicaid State Plan.

"Health Care Administrative Rules" or **"HCAR"** mean the collection of regulations adopted by the Agency of Human Services that govern the administration of Vermont Medicaid, including general provisions, eligibility, benefit delivery, covered services, reimbursement, specialized services, beneficiary rights, and provider responsibilities.

"Medicare" means the health insurance program for the aged and disabled under Title XVIII of the Social Security Act.

"Provider" means any individual or entity who has entered into an agreement with the Agency of Human Services or any of its departments, offices, or divisions, to provide services covered by Vermont Medicaid.

"Provider Manuals" means policy and procedure documents outlining the policies and practices for medical providers enrolled with Vermont Medicaid. Manuals are made publically available for medical coverage and medical programs administered by the Agency.

"State Plan" means the agreement between Vermont and the Centers for Medicare and Medicaid Services approved under Title XIX of the Social Security Act describing how Vermont administers its Medicaid program.

"Vermont Medicaid" means the medical assistance provided under the State Plan approved under Title XIX of the Social Security Act, and the terms and conditions of the Global Commitment to Health Waiver, as approved by CMS.